Paul R. Young, M.D. PLLC

Pediatric

GENERAL INFORMATION

Today's Date: _____ / _____ / _____ Social Security Number: _______-_______-________

Patient's Name: ______________________________ ______________________________ Date of Birth: _______ / _______ / ________

Last Name First Name MI

Address: ____

Number / Street City State Zip

Parent / Guardian's Name: ____

Last Name First Name MI

Address: ____

Number / Street City State Zip

Phone Numbers: Home ( )_________________ Cell ( )___________________ Work ( )___________________

If we need to contact you, which is the preferred number? ☐ Home ☐ Cell ☐ Work

Does the above person have the legal authority to make medical decisions? ☐ Yes ☐ No If No Whom?_______________________

Can we leave a message at this number on the answering machine? ☐ Yes ☐ No

Parent or Guardian's Email Address:____

Preferred Pharmacy (Name & Address): ____

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Government regulations require we ask for the following identifying information for the patient.

Gender: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian/Alaska Native ☐ Other__________________

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Primary Preferred Language: ☐ English ☐ Spanish ☐ Other:______________________________

REFERRING DOCTOR:

Did a doctor send you and do you want us to send the doctor a report about today's visit? ☐ Yes ☐ No

Doctor's Name: ______________________________ Primary care Doctor's Name:____________________________

PEDIATRIC REVIEW OF SYSTEMS: (If experiencing any of the below symptoms, please circle.)

General Constitutional:
- Change In Appetite
- Chills
- Fever
- Weight Loss
- Excessive Bruising/ Bleeding
- Passed New Born Hearing/Screening Test
- Speech Problems
- Language Delays
- Mouth Breathing
- Snoring/Noisy Breathing
- Hoarseness/Voice Changing
- Frequent Nosebleeds

Cardiovascular:
- Chest Pain (Rest)
- Irregular Heartbeat

Musculoskeletal:
- Painful Joints
- Swollen Joints

Ophthalmologic (Eyes):
- Blurred Vision
- Pink Eye/Conjunctivitis
- Vision Problems

Skin:
- Itching
- Rashes

Ear, Nose, and Throat:
- Frequent Ear Infections
- Frequent Sinus Infections
- Frequent Strep Throat/Tonsillitis
- Decreased Hearing
- Ringing in Ears

Respiratory:
- Cough
- Shortness of Breath (At Rest)
- Wheezing

Gastrointestinal:
- Abdominal Pain
- Diarrhea
- Vomiting
- GERD/Heartburn

Neurologic:
- Dizziness
- Headaches

Genitourinary:
- Blood In Urine
- Painful Urination
- Bedwetting

PAST MEDICAL HISTORY: (Please circle the symptoms below to indicate.)
Indicate if you have any of the medical problems listed below and add any additional problems not covered in the space provided.

- ☐ ☐ Down's Syndrome
- ☐ ☐ Autism
- ☐ ☐ Learning Disorder
- ☐ ☐ ADHA / Hyperactivity
- ☐ ☐ Environmental Allergies
- ☐ ☐ Premature Birth
- ☐ ☐ Recurrent / Frequent Croup
- ☐ ☐ Heart Defect
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart / Thoracic Surgery
- ☐ ☐ Asthma
- ☐ ☐ Pneumonia
- ☐ ☐ GERD
- ☐ ☐ Kidney / Renal Disease
- ☐ ☐ History of Cancer
  Type: ______________________________
- ☐ ☐ Diabetes
- ☐ ☐ Bleeding Disorders
- ☐ ☐ Thyroid Disease
- ☐ ☐ History of Migraine Headaches
- ☐ ☐ Immune Deficiency
- ☐ ☐ Seizures
- ☐ ☐ Eczema
- ☐ ☐ Other: ______________________________

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SOCIAL HISTORY

Is the patient in Daycare? ☐ Yes ☐ No

Is there smoke exposure at home? ☐ Yes ☐ No

Are the patient's immunizations up to date? ☐ Yes ☐ No

Does the patient have brothers and/or sisters? ☐ Yes ☐ No If YES how many?______________________________

FAMILY HISTORY: (Please circle symptoms below to indicate.)
Do any of these diseases run in your family:

- ☐ ☐ Diabetes (Please select: Maternal or Paternal side)
- ☐ ☐ Cancer (Please select: Maternal or Paternal side)
- ☐ ☐ Heart Disease (Please select: Maternal or Paternal side)
- ☐ ☐ Bleeding Disorders (Please select: Maternal or Paternal side)
- ☐ ☐ Anesthesia Complications (Please select: Maternal or Paternal side)
- ☐ ☐ Others: ______________________________

PAST SURGICAL HISTORY: Please list previous surgeries.

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CURRENT MEDICATIONS: Please indicate doses and how often you take.

Medication	Dose	Frequency

ALLERGIES TO MEDICATIONS:

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